ABD Taskforce Presentation

Indiana Health Care Association

August 16th, 2013

Why are States Choosing Managed Care for LTSS?

- Control Costs
- Expand HCBS/Community Inclusion
- Increase Quality and Efficiency

None of these goals is an exclusive domain of managed care-led programming

Recent FSSA Actions/Results

- Controlled Costs
  - $500m+ in SFY12/13 Medicaid Reversions[1]
  - $172m in SFY10/11 Medicaid Reversions[1]
  - Continued, albeit reduced, rate cuts 1/1/14
    - NF rate cuts totaled $135.5M in SFY 12/13 (State & Fed dollars)
    - NF rate cuts are expected to be $92M in SFY 14/15 (State & Fed dollars)

- Expanded HCBS/Community Inclusion
  - A&D Waiver Growth since 2003 = 180% [2]
  - Nursing Facility Growth since 2003 = -.9% [2]
  - Medicaid Utilization of NF beds has decreased
    - July 1, 2003 = 68%; July 1, 2013 = 63% [3]
  - Increased HCBS expenditures by $426m last biennium [4]
  - Eliminated incentive for NF admission of low-need residents in Phase 2 of NF QAF program
  - MFP Program
  - Balancing Incentives Payment Program

Recent FSSA Actions/Results

- Increased Quality and Efficiency
  - NF Quality Assessment Fee
    - Phase 2 – based incentives upon regulatory and clinical compliance standards – marked improvement seen
    - Phase 3/Value Based Purchasing – based incentives upon compliance standards, plus direct care nurse hours per day, retention/turnover, and administrative leadership retention
    - Phase 4/Value Based Purchasing – beginning work to incorporate resident, family and staff satisfaction, and specific clinical outcome measures
      - Will be one of if not the most robust incentive program in the nation

OMPP Should Continue to Managed NF clients directly-not via an MCO

- Quality initiatives with NF clients and providers are showing positive results, and providers are willing to continue improving the system

- Risk of destroying positive use of QAF and Medicaid Supplemental Payments
  - QAF, since 2003, has resulted in $924M for NF reimbursement and $280M for other Medicaid expenditures
  - Approximately 22% of the NF reimbursement rate depends on the QAF
  - Just more than 50% of Indiana's NFs are part of a county hospital resulting in supplemental payments used for clinical, staff, and physical plant improvements without use of any State money

MCO LTSS Experience is too new

- Medicaid MCOs for LTSS are very new, with the exception of Arizona, and few reports exist on outcome results of financial and clinical measures.
- MCO-led LTSS can be more expensive – New Mexico found a 60% increase from FY07 to FY12 in its program that included NF, HCBS, and personal care. A program redesign was required.[5]

MCO LTSS Experience is too new

- Minnesota's MCO experience has had little focus on NF clinical outcome measures[6]
- MCO Medical Loss Ratios (MLR) are high and causing some MCOs to withdraw from contracts[7]
  - Centene withdrew from its contract in Kentucky in August 2013
  - High MLRs are not necessarily a bad thing for beneficiaries, providers and the State – tax dollars should go towards care
  - Setting capitation rates with new populations that have not been in managed care before is proving to be difficult

MCO Must Haves if ABD is shifted to managed care

1. Access and Quality must come first – not constraints of cost via payment and length of stay reductions
2. States and Plans should have demonstrated experience with managed LTSS
3. Clients/Beneficiaries should have meaningful opportunities to make educated decisions about their care
4. Independent grievance and appeals for individuals and providers should be in place and adequately funded

MCO Must Haves if ABD is shifted to managed care

5. Access must be ensured when patients and residents need it (network adequacy)
6. Administrative consistency across plans is essential
7. Care coordination should produce efficiencies and the health care experience to the client
8. All views should be considered when developing a program
9. Provider reimbursement should align with program standards and access goals

Non-MCO Approaches

- Continue Improving Medicaid Value Based Purchasing with NFs
- Explore case management alternatives that can assist improving known difficulties in the NF population such as care transitions, antipsychotic medication use, and falls

References

1. State Budget Agency Data
2. Division of Aging Presentation to Select Joint Commission on Medicaid Oversight, October 24, 2012.
3. Meyer & Stauffer Nursing Facility data, see http://in.mslc.com/Resources/Documents.aspx
4. FSSA Budget Presentation to the Budget Committee, December 12, 2012
5. Report to the Legislative Finance Committee, Human Services Department, Program Evaluation: Medicaid Coordination of Long-Term Services Program, February 14, 2011.
6. Minnesota Department of Human Services, Performance Improvement Projects, Annual Summary Report, July 2012.
7. Avalere, Medicaid Monthly/Federal & State Issues, August 2013.